is a relatively common disease in negroes and Mexicans, but the case we are about to report is the first we have seen or heard of about granuloma venereum of the rectum. There undoubtedly have been many similar cases, but we have found none in the literature.

REPORT OF CASE

H. C., married, negro male, age twenty-nine, entered the hospital for the first time on December 14, 1937, complaining of watery bowel movements, a symptom existing for seven months. He had had seven to eight stools a day for seven months, the material being thin and watery, sometimes pink in color, but never deeply red. He had bowel urgency and tenesmus. In all he had lost fifteen pounds. He had frequent chills and night-sweats, but otherwise was generally symptom-free. His past history was noncontributory, except that he had had typhoid at the age of four. He denied all types of venereal infection, and stated that he had never had any penile or scrotal lesions. He had been married for five years; his wife had remained childless, and no contraceptives were used. He was born in Texas, but had lived in Oakland, California, for the past two years. On examination a well-developed, well-nourished young negro male was found. Temperature was 99.6; pulse, 76; blood pressure, 122/68. The abdomen was soft, not tender, and contained no palpable masses. The rectal sphincter tone was normal, but there were several small nodules felt in the mucosa. Genitalia were normal. Sigmoidoscopy showed nodular, condylomatous, firm masses on all sides of the lumen of the bowel, but no open ulcerations. The mucosa bled freely; there was a thin, purulent discharge present. Laboratory reports showed a hemoglobin of 6.42 grams; red blood count, 3.05 million; and white blood count, 11,500. There were no ova or parasites in the stool. The intracutaneous tuberculin was positive to 0.1 milligram of O. T. The Frei test was negative. Roentgen examination of the chest showed clear lung fields, and of the colon a slightly dilated bowel along its entire course. There were no defects in outline. Biopsy of the rectal mucosa was reported "non-specific inflammation." The spinal fluid was within normal limits. The blood Wassermann was negative. The course while in the hospital exhibited a daily intermittent fever as high as 103 degrees, associated with chills. The fever decreased and was near normal on discharge. No specific therapy was instituted, and the patient was discharged with a diagnosis of "chronic colitis."

The patient's second entry to the hospital was on August 10, 1938, prompted by an increasing loss of weight (thirty pounds total loss), and still greater frequency of bowel movements. For a few months after first dismissal he had gained weight and strength, but for three months prior to entry had again declined in health until, on entry, he was having ten to fifteen passages per day, accompanied by chills and abdominal discomfort. Physical examination revealed little change from the first examination, except that the patient was thinner and paler. Examination of the rectum and sigmoid revealed a mucosa "thrown into irregular indurated folds which are friable and bleed easily." The hemoglobin was 3.88 grams per cent; red blood count, 2.36 million; and white blood count, 10,350. Barium enema done this time showed a constriction of the rectum and sigmoid with ulcerations. The gastric analysis was within normal limits. Ova and parasites were not found in a series of stool examinations. Biopsy of rectal mucosa was again reported as nonspecific purulent inflammation. A diagnosis of "chronic ulcerative colitis" was made, and ileocecostomy advised. This operation was performed, and after convalescence the patient was discharged.

The patient again reëntered the hospital on March 5, 1939. There had been a continuance of rectal bleeding and irritation. His general health was run down and he had become a chronic invalid. The cecum and ileum protruded from the cecostomy opening about six inches. The hemoglobin was 6.9 grams and rose during stay in hospital to 7.2 grams. He was transfused twice. Biopsy of the rectal mucosa showed chronic nonspecific inflammation. The ileocecostomy was closed and a colostomy of the descending colon made. The patient was discharged improved.

The patient's last entry to the hospital was on August 28, 1939. During the interval since his last discharge, he had gained twenty pounds in weight and had greatly improved in general health. The colostomy was functioning well, but he was still having passages of blood from the rectum about five times daily. Examination of the rectum showed a similar picture as previously, the mucosa being thrown up in polypoid masses like hobnails. There was an indolent ulcer at the anus. There were no polyps or other abnormalities of the proximal colostomy loop. Biopsy taken from one of the rectal "polyps" showed typical Donovan bodies within the large mononuclear cells, and an infiltration of plasma cells within the mucosa. A diagnosis of granuloma venereum was made. The patient was started on a series of intravenous injections of tartar emetic, starting at 0.02 gram per dose, and repeating every other day with gradually increasing dosage until a dose of 0.10 gram was given. At the same time the portion of the bowel from the distal colostomy loop to the anus was irrigated with acriflavin solution, 1:5000. There was improvement in the rectal bleeding and stool frequency. The number of bowel movements dropped to about three in twenty-four hours. The patient was discharged, improved, to the Out-Patient Department, where he has been followed, receiving his full course of tartar emetic therapy.

COMMENT

Although there had been temporary improvement in the rectal bleeding and tenesmus, the condition has become stationary. The mucosa still has the same appearance, and bloody mucus still discharges from the distal colostomy loop. The colon from the proximal colostomy loop is uninvolved. The opinion of the staff at present is practically unanimous that only a resection of the bowel from colostomy to anus will give this patient permanent relief.

Since the diagnosis of granuloma venereum was made from the last biopsy, the slides of previous biopsies have been reviewed. Although not so typical a picture of this pathologic process, Donovan bodies were seen in some of the previous sections.

Alameda County Hospital.

CLINICAL NOTES AND CASE REPORTS

SYPHILIS IN RELATION TO THE HUSBAND, THE WIFE, AND THEIR OFFSPRING*

By BENJAMIN BAKEWELL, M.D.
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THIS review of family relationship and syphilis was inspired by a recent experience with a rather unusual setting, as will be seen by the following history.

REPORT OF CASE

Mrs. F. O., a Spanish-American woman, aged 28 years, came to me on May 9 to be cared for during her pregnancy and delivery. She was at that time approximately three and one-half months pregnant. She had had no abortions up to the time her first child was born. This child was a home delivery, weighing 10½ pounds, and it lived only one-half hour after birth. The second and third pregnancies were normal in every respect, and these two children are well developed and healthy at the present time, aged 5 and 2½ years, respectively. A Wassermann has not been done

* From the Santa Barbara Clinic.

on these children. The fourth pregnancy was aborted about one year ago at three months, after a long automobile ride. During the present pregnancy, her fifth, the prenatal examination and care were routine and uneventful, her Wassermann being negative. On June 27th, she being then about four and one-half months pregnant, began to have cramps and to flow. She entered the hospital, and in spite of every effort to control the bleeding, it was found necessary on July 7 to induce labor in order to put a stop to any further loss of blood. A few hours later she passed a dead fetus, with macerated head, the placenta showing an adherent, partially organized clot over about one-third of its surface, but with no other gross evidence of disease. Before the induction it was feared that a blood transfusion might be necessary, and to prepare for this her husband's blood was typed and a routine Wassermann was done on him. His Wassermann was 4 plus positive. It is needless to add that the idea of using his blood for a transfusion was abandoned. The Wassermann tests of both the man and his wife were then rechecked, with no change in the findings. It was possible to get cord blood from the fetus for a Wassermann, and this was negative. Sections of the placenta, the liver and the spleen of the fetus, examined under the direction of our pathologist, did *not* reveal the presence of Spirocheta pallida.

COMMENT

The salient features of this case, then, are as follows: The husband has a 4 plus Wassermann. The wife has a negative Wassermann. Her first pregnancy resulted in a child which went to full term and died at birth, weighing 10½ pounds. The next two pregnancies produced healthy children. The next aborted at three months, after possible trauma, while the last or fifth developed a dead fetus delivered at four and one-half months; but evidence of syphilis cannot be demonstrated.

Let us now review the possibilities:

1. The wife may be free from syphilis. Reliable authorities state that if the man's infection is from five to seven years' duration, treated or untreated, he may marry and his wife will not acquire the disease. In this case I can get no history of a primary infection in the man, so that the years' duration of his infection is unknown.

2. The wife may have a latent infection. Such women may or may not convey the disease to their offspring, but the probability of such conveyance is dependent somewhat on the age of her infection; one of many years' standing being less likely to be transmitted than a recent one, and the infection of the child is more severe and more apt to cause early abortion in the earlier pregnancies. Our case would seem to follow the reverse of this tendency.

3. The husband may have acquired syphilis since the birth of the two healthy children. This possibility cannot be disproved, but it seems probable that he would have found it difficult to conceal this circumstance from his wife. His history does not suggest such a condition. It is possible that he might have overlooked a youthful infection with a mild course, to the extent he now would state that he never had syphilis; but this would not hold for a recent infection.

4. The father might have infected the child at the time of conception through the means of infected semen without the mother acquiring syphilis. This used to be considered possible; but modern methods of study and research would seem to prove such a possibility highly improbable, and modern opinion is against this method of transmission.

Now let us review the steps that should be taken in the treatment of this rather complicated situation. Immediately we come up against the economic and sociologic aspects of the case. The father is a working man of the limited income group, of moderate intelligence, but ignorant of the more or less remote potentialities of his condition, and resentful of the findings. He should, of course, begin treatment at once for his syphilis and, if unwilling to do so, can be legally compelled to submit. The two apparently healthy children should have Wassermann tests taken, and this also can be done through the legal authorities, if necessary. It should be remembered that one or both of these children may be clinically free from symptoms of the disease to the age of eighteen years and subsequently develop a keratitis. The mother should have a spinal fluid Wassermann taken; but if this is negative and her two children have negative Wassermanns, my opinion is, considering that the five and one-half month fetus showed no evidence of syphilis, that she should not be treated. If, however, she again becomes pregnant, it would be wise to give her a provocative test, the result of such test determining whether or not she should be treated during the pregnancy.*

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HIPPOCRATES' APHORISMS†

By M. Scholtz, M.D.
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Section One

16. 'Tis proper in diseases bearing fever
To keep the patients on a liquid food;
Especially young children and all persons
Who have acquired such eating habitude.

17. To estimate the frequency and size
Of feedings for a patient, the healer must
Consider age, his and his country's habits—
Then only can he properly adjust.

18. Food is borne worst in summer and in autumn,
Most easily in winter and in spring.

19. In periodic paroxysms of illness,
Don't serve the sick his customary ration;
But just before such spell may be expected
Put him on a mild and relative starvation.

20. In time of crisis and shortly after it,
Don't move the bowels nor change your recipe
In the used stimulant and purging methods;
Continue, better, the same therapy.

* September 29, 1939.—Since this report was written, I have information that the father is being treated at the County Clinic; the two children, also, have reported to me for serological tests, and are found to have negative reactions.
In the report, where the term Wassermann is used, it is understood that I refer to the usual complete serological tests—Kahn, Eagle and Laughlin.

† For other aphorisms, see California and Western Medicine, March, 1940, on page 125.